Whom may we thank for referring you to this office → _____*?*

Maximize Chiropractic – PREGNANCY HEALTH HISTORY FORM

Today's Date: _____ HR#: _____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ SS# _____

E-mail address _____

Occupation _____ Employer _____

Marital Status ❑ S ❑ M Spouse/Partner _____

Names and Ages of Children _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Maximize Chiropractic can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑ N Name of D.C. _____

How long under care? ❑ _____days ❑_____weeks ❑_____months ❑_____ years

Date of last visit: _____Why did you stop care?_____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath

❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason:_____

Gestation Date: _____weeks

Due Date _____ Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other _____

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how YOU were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

_____

Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

_____

Have you ever broken or fractured any bones? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents' divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

_____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

_____

_____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall "quality of life"?	❑ Good	❑ Fair	❑ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

❒ OTHER_____

PREGNANCY HEALTH HISTORY

FERTILITY HISTORY

Did you have any difficulty in conceiving? _____

How long had you been trying before becoming pregnant? _____

When was your last missed period? _____

Have you ever use any of these fertility methods/drugs? (Please circle all that apply)

IVF:	Y	N	Ovidrel:	Y	N	Other: _____
IUI:	Y	N	Femara:	Y	N	Other: _____
Metformin:	Y	N	Eating:	Y	N	Other: _____

BIRTH HISTORY

Do you have a birth plan? Y N

What Birth # is this? _____

Who was your chiropractor for previous births? _____

Any prior miscarriages? Y N

Do you know the sex? Y N Plan to find out? Y N

How long were previous labors? _____

_____

Have you had any ultrasounds? Y N

If yes, please list the medical reason it was done: _____

_____

Who is on your birth team? (Please circle all that apply)

Doula:	Y	N	Husband:	Y	N	Other: _____
Midwife:	Y	N	Kids:	Y	N	Other: _____
OB:	Y	N	None:	Y	N	Other: _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

Name of OBGYN or Midwife_____ Estimated Due Date: _____

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services I receive at this office.

Cancellation Policy – 24 hour notice for all scheduled appointments - $65 fee

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Nicholl Chiropractic Inc. NOTICE OF PRIVACY PRACTICE

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost @ $25.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call the office at (916) 594-7630. If she/he is unavailable, you may make an appointment with our receptionist to see her /him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights

200 Independence Ave. SW

Room 509F HHH Building

Washington DC 20201

I have received a copy of Nicholl Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

Office Fee Schedule

Service	***Fees***
Consultation	Free
Initial Exam	$50.00 - 137.00
X-rays	$87.00 - 200.00
Adjustments	$55.00 – 75.00
Ancillary Procedures	$30.00 – 60.00

Financial Policy

You will be expected to pay for your chiropractic care at the time service is rendered unless discussed with the office prior.

Cash- Charges for care in this office are due at the time of your service. Cash patients are able to obtain upwards of a **60% discount** under representation from Compliant Coupons. Every patient will be automatically enrolled with Compliant Coupons.

Health Insurance- Every patient is asked to place a $130 deposit for services rendered on the 1st appointment. Once a diagnosis code
is established by the doctor, office staff will obtain detailed information on coverage opportunities in the office. If insurance covers care, the deposit will be returned to patient or applied towards co-pays and deductibles. If no coverage is present, no additional charges will
be placed for the 1st visit. We will accept your assignment of benefits; however you must remember you are directly responsible for your bill.

"If my health insurance company denies payment, I agree to be personally and fully responsible for payment."

Medicare- Medicare will not pay for x-rays or an exam; however they require them before they will pay for your treatments'. You will
be responsible for the cost of your x-rays' and exam. If you have not met your deductible, this must also be satisfied. Medicare will cover 80% of the adjustment; no additional services are covered. A yearly deductible of $147 must be met for Medicare to pay for their portion. If you have not met your deductible you will be responsible for this.

Personal Injury- (Auto Accident) If you have medical coverage (Med-Pay) on your auto insurance policy, we will bill them for prompt and direct payment for your care. (Med-Pay will cover your doctor's bill regardless of who was at fault). If you do not have Med-Pay we will defer to a third party lien however we do require that you obtain an attorney. If you do not have one, we can recommend several attorney's for you.

Cancellation Policy

24 hour cancellation for scheduled appointments must be respected or appointment will be charged $65.

_____ _____

Patient's Signature Date

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Nicholl Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____/_____/_____  *Witness Initials*

Patient or Authorized person's Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages: Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____